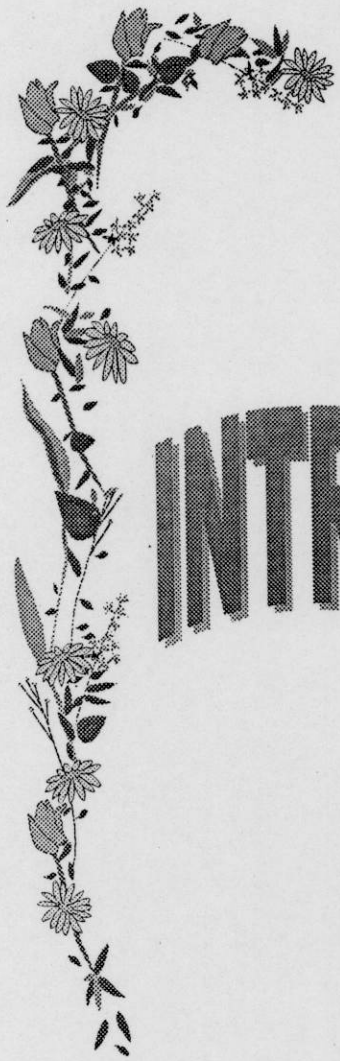

INTRODUCTION

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Over the last decade arthroscopy of the ankle joint has become an important diagnostic and therapeutic procedure in chronic and post traumatic complains of the ankle joint.

Burman in (1931) regarded the ankle joint unsuitable for arthroscopy, because of its typical anatomy as the narrow joint space and convex talus.

Tagaki (1939) was the first one to describe the systematic arthroscopic assessment of the ankle joint, ***Watanabe (1972)*** published aseries of 28 ankle arthroscopies followed by ***Chen in 1976*** ***(Van Dijk, 1997).***

Arthroscopic examination of the ankle joint premits direct views and palpation of all intra articular structures without the morbidity of extensive surgical exposures.

Dynamic correlation of the mechanisms of injury is also possible by viewing the joint in motion and under applied stress intraoperatively.

The chondral surfaces, and soft tissue structures i.e., synovium, ligaments, and capsule, can be directly assessed. Small joint arthroscopic instrumentation enables the surgeon to perform

numerous surgical procedures, such as biopsy, chondroplasty, debridement, synovectomy and loose body removal, with great accuracy and relative ease.

The generally "less invasive" nature of arthroscopic procedures decreases postoperative discomfort and morbidity and facilitates rehabilitation and an expeditions return to normal activities.

The potential disadvantages of ankle arthroscopy are few but include most of the complications inherent to all arthroscopic procedures, such as infection, chondral damage, neuro vascular injury, along with the requirement and expense of special instrumentation, the acquisition and refinement of specific surgical skills and the risk of equipment failure ***(Ferkel and Fasulo, 1994).***